DOCUMENT RESUME

ED 327 762 CG 023 066

AUTHOR Silverman, Wade
TITLE Reflections on Psychotherapy and Aerobic Exercise.
PUB DATE 12 Aug 90
NOTE 8p.; Paper presented at the Annual Convention of the American Psychological Association (98th, Boston, MA, August 10-14, 1990).
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Aerobics; Body Image; Bulimia; Depression (Psychology); Eating Habits; *Emotional Adjustment; Emotional Disturbances; *Exercise; Physical Health; *Psychopathology; *Psychotherapy

ABSTRACT

This document provides a series of reflections by a practicing psychologist on the uses of aerobic workouts in psychotherapy. Two case histories are cited to illustrate the contention that the mode of exercise, rather than simply its presence or absence, is the significant indicator of a patient's emotional well-being or psychopathology. The first case illustrates the abuse of physical exercise through a bulimic patient who alternately gorged on food and then absolved herself by spending hours every day at a health club, exercising and jogging to keep her weight down. In this case, exercise was seen as a reflection of the client's emotional disorder rather than a solution. The counterexample is of an overweight client with chronic depression for whom exercise was a marker of psychological adjustment, along with work habits, sexual habits, and eating and drinking habits. It was concluded that depending on the context, aerobic exercise such as jogging can be either a compulsion, indicative of the problem itself, or a successful therapeutic intervention to enhance physical health and emotional well-being. (TE)

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REFLECTIONS ON PSYCHOTHERAPY AND AEROBIC EXERCISE

WADE SILVERMAN, Ph.D.
CHAIR, DEPARTMENT OF PSYCHOLOGY
BARRY UNIVERSITY
11300 N.E. Second Avenue
Miami Shores, Florida 33161
(305) 758-3392, X585

Presented at 98th Annual Convention
of the
American Psychological Association
at
Boston, Massachusetts
August 1990

* * *

Sunday, August 12, 9AM-10:50AM
Sheraton's Constitution Room

CG023066

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REFLECTIONS ON PSYCHOTHERAPY AND AEROBIC EXERCISE

It is generally accepted that a regimen of aerobic workouts contributes to physical health and emotional well-being. I strongly support the view that an integral part of any clinical assessment interview is an inquiry into the exercise routine of the client.

My experience with clients has taught me that the relationship between exercise and emotional well-being is complex. Whereas I used to simply consider aerobic fitness a cause or at least a correlate of emotional well-being, I have now changed my views. I would argue that it is not whether one exercises, but how one exercises that is the real reflection of emotional well-being or psychopathology.

About ten years ago, a young woman, Ms. G, in her early 30's came to my office to seek assistance. She was very self-conscious about her speech impediment, a slight stutter. Although she was one of the more successful businesswomen in town, Ms. G was painfully shy in social settings because of her dread of stuttering. When we were able to control this problem, she presented another--bulimia. Ms. G would gorge on food and ruminate in self-recrimination. Her absolution was exercise. She would spend hours every day at a health club. She would do aerobic exercises, jog, and play racquetball to keep her weight down. On several occasions, she jogged to our appointment. Despite all efforts to broaden her

interests, Ms. G felt empty without her work and her exercise routine. Obviously, she was running away from her demons. I could never persuade her to directly address the emotional void, the emptiness in her life. Exercise and work were addictions which when halted caused her to face her pain. It was clear to me that Ms. G's exercise routine was a reflection of her emotional disorder rather than a positive force in her life.

Ms. R presented an opposite picture. She came to therapy because of chronic depression. She was a 27-year-old female recently graduated from law school who was very unhappy with her profession and her social life. She was overweight and carried an ever-present scowl on her face. As therapy progressed, she confessed to being an intellectual snob, not even bothering to practice social amenities to those she considered inferior at work or leisure gatherings. Without getting into the details of the dynamics of this case, our main goal was to increase social interactions. For the first time in her life, Ms. R began to date on a regular basis and within six months began her first sexual experience. As she continued to improve, she became interested in jogging. Her interest developed into a hobby and she joined a running club. This also enhanced her social life. There was a dramatic change in her physical appearance as well as her outlook on life. Ms. R successfully terminated psychotherapy. Although she has

returned on a couple of occasions for some short-term work, she has basically maintained both her perspective and her weight. She continues to exercise on a regular basis. These cases illustrate the use or abuse of exercise. The habit of exercise is a marker of psychological adjustment, just as are work habits, sexual habits, and eating and drinking habits.

This point of view applies to a normal population as well. Two colleagues and I studied the relationship between running and mood changes in a population of athlete runners (Maharam, Silverman, & Silverman, 1986). The subjects were members of two voluntary running clubs. To our surprise, we found an inverse relationship between miles run per week and mood elevation, leading us to suspect that this non-clinical population keeps fit for reasons other than health or enjoyment.

What are these reasons? There is not much in the literature to guide us. My view is that, for many, running takes on the qualities of a compulsion. It becomes a ritual in which the excessiveness of its execution is self-defeating (Runck, 1983). The original meaning or reason for the behavior becomes distorted, or out of touch with its original intent as illustrated below: "My major accomplishment in life is my running," or "If I don't improve or if I stop for any reason, I am a loser." "Running is the only reason why I lost weight," or "If I let

up, I will lose all control."

The compulsive act of exercise provides the individual with some control over anxiety associated with feelings of being overwhelmed, defeated, or humiliated (Jenike, 1983). As with any other type of irrational solution, it doesn't solve the problem for which it was intended. There are enough rewarding properties other than problem resolution, e.g. avoidance or escape, to maintain the exercise ritual, unless and until the realities of life intervene--demands of work or home life--or the source of the emotional problem--negative self-esteem, fear of failure--becomes exacerbated.

The therapist can treat this as he/she would any other form of compulsion. For the dynamic therapist, the goal is to ascertain the underlying conflict which this ritual symbolizes, to resolve it, and to assist the client in healthier behavior (Renik, 1981). For the behaviorally-oriented therapist the goal is to extinguish the anxiety associated with not exercising through response prevention, systematic desensitization, or flooding (see Steketee, Foa, & Grayson, 1982 ;Silverman, 1986). The cognitive therapist would identify and then attack the unrealistic or illogical beliefs associated with the act of exercising, e.g. "I have not exercised enough this week," or "If I don't exercise I will (take your pick) die, become fat, or lose my sense of self." (Davison & Neale, 1990).

Success rates for interventions of obsessive compulsive

disorders are high with a reported range between 75% to 85%. Treatment failure has been associated with a severe underlying depression or the belief that the irrational fear is valid (Foa, 1979).

In summation, aerobic exercise enhances physical health and emotional well-being. Psychotherapists can and do encourage these efforts. However, it is important to understand and be alert to the fact that self-defeating behavior can mask as health enhancement. With respect to aerobic exercise, this can definitely be too much of a good thing.

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